MO 640–826

Two-Day OASIS Training
April 22–23, 2008

Presented by: Kim Hall, RN, Cos-C

ADL'S/IADL'S- Key OASIS Considerations

- Direct observation preferred
- Current status under consideration
- No reference to prior assessments
- Minimize use of NA/Unknown
- Usual status/Most of the time

Scoring Considerations

- Ability, Not performance
  - Does not necessarily mean willingness or actual performance
  - Ability may be temporally or permanently limited by: physical impairments, emotional or cognitive behavior, sensory impairments, environmental barriers, medical restrictions
  - ***Ability infers safety***
  - Determine safety through skilled observation
  - Evaluate:
    - ***Technique used***
    - ***Equipment used***
    - ***Risk for injury***

Scoring Considerations cont.

- When ability varies over time: report ability greater than 50% of the time.
- When ability varies between tasks:
  - Consider frequency of each activity
  - Response describes patients ability in the majority of tasks

Ability cont.

- **Disregard presence/absence of caregiver when determining ability to complete tasks**

ADL/IADL

- **<u>ADL/IADLs</u>**
- **For M0640-M0800, complete the "Current" column for all patients. For these same items, complete the "Prior" column only at start of care and at resumption of care; mark the level that corresponds to the patient's condition 14 days prior to start of care date (M0030) or resumption of care date (M0032). In all cases, record what the patient is *able to do*.**

MO640

- **(M0640) Grooming:** Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).
- Prior Current
- ¨ ¨ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ¨ ¨ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ¨ ¨ 2 - Someone must assist the patient to groom self.
- ¨ ¨ 3 - Patient depends entirely upon someone else for grooming needs.
- ¨ UK - Unknown

- **DEFINITION:** Identifies the patient's ability to tend to personal hygiene needs, excluding bathing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:** Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO640 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:** Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities but unable to do less frequently performed activities should be considered to have more grooming ability.Response 2 includes standby assistance or verbal cueing."UK - Unknown" is an option only in the "Prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**
  A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient gathering equipment needed for grooming. The patient can verbally report the procedure used for grooming and demonstrate the motions utilized in grooming (e.g., hand to head for combing, hand to mouth for teeth care, etc.). The clinician should also observe the general appearance of the patient (to assess grooming deficiencies) and verify upper extremity strength, coordination, and manual dexterity to determine if the patient requires assistance with grooming. A poorly groomed patient who possesses the coordination, manual dexterity, upper-extremity range of motion, and cognitive/emotional status to perform grooming activities should be evaluated according to his/her ability to groom.

MO640 cont.

- Assessment of the patients coordination, manual dexterity, upper extremity range of motion (hand to head, hand to mouth, ect), and cognitive/emotional status will allow the clinician to evaluate the patients ability to perform grooming activities.
- **Note:** Shampooing the hair is not scored in grooming and/or bathing.

MO650

- **(M0650) Ability to Dress Upper Body** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
- Prior Current
- ¨ ¨ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the up-per body without assistance.
- ¨ ¨ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ¨ ¨ 2 - Someone must help the patient put on upper body clothing.
- ¨ ¨ 3 - Patient depends entirely upon another person to dress the upper body.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:** Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

MO650 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:** If the patient requires standby assistance (a "spotter") to dress safely or requires verbal cueing/reminders, then Response 2 applies. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:** A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

MO 650 cont.

- The assessment should include the skills necessary to manage zippers, buttons, hooks, ect.
- The appropriate response should indicate the patient's ability to dress herself (or the level of assistance needed to dress) in whatever clothing she would routinely wear. (If all the shirts in the closet have buttons, and she is wearing a pullover smock that looks new…explore her true ability.

MO660

- **(M0660) Ability to Dress Lower Body** (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
- Prior Current
- ¨ ¨ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ¨ ¨ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ¨ ¨ 2 - Someone must help the patient put on under-garments, slacks, socks or nylons, and shoes.
- ¨ ¨ 3 - Patient depends entirely upon another person to dress lower body.
- ¨ UK - Unknown
- **DEFINITION:**Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:**Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

MO660 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**If the patient must apply a lower-extremity prosthesis, this prosthesis should be considered as part of the lower-body apparel. If the patient requires standby assistance (a "spotter") to dress safely or verbal cueing/reminders, Response 2 applies."UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- .**ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

MO670

- **(M0670)Bathing:** Ability to wash entire body. **Excludes grooming (washing face and hands only).**
- Prior Current
- ¨ ¨ 0 - Able to bathe self in shower or tub independently.
- ¨ ¨ 1 - With the use of devices, is able to bathe self in shower or tub independently.
- ¨ ¨ 2 - Able to bathe in shower or tub with the assistance of another person:
- (a) for intermittent supervision or encouragement or reminders, OR
- (b) to get in and out of the shower or tub, OR
- (c) for washing difficult to reach areas.
- ¨ ¨ 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ¨ ¨ 4 - Unable to use the shower or tub and is bathed in bed or bedside chair.
- ¨ ¨ 5 - Unable to effectively participate in bathing and is totally bathed by another person.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the patient's ability to bathe entire body and the assistance which may be required to safely bathe in shower or tub. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:**
- Start of care - prior and current ability
- Resumption of care - prior and current ability
- Follow-up - current ability
- Discharge from agency - not to an inpatient facility -- current ability

MO670 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:** The patient who bathes independently at the sink must be assessed in relation to his/her ability to bathe in tub or shower. Is assistance needed for the patient to bathe in tub or shower? If so, what type of assistance?"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then Response 2 or Response 3 applies, depending on the quantity of assistance needed.If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities.If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, Response 0 or 1 would apply, depending on the need for devices to safely perform the task independently.

MO670 cont.

- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.

MO670 cont.

- **Q134. M0670. Given the following situations, what would be the appropriate responses to M0670?**
- **a) The patient's tub or shower is nonfunctioning or is not safe for use.**
- **b) The patient is on physician-ordered bed rest.**
- **c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.**
- **d) The patient chooses not to navigate the stairs to the tub/shower.**
- A134. a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.
- b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment.
- c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then response 3 would describe her ability.
- d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured. [Q&A EDITED 08/07

MO 670 cont

- **Not to be considered:**
  - **Gathering supplies**
  - **Preparing the water**
  - **Shampooing hair**
  - **Drying off after bath**
  - ***Transferring in/out of tub/shower***

MO680

- **(M0680)** **Toileting:** Ability to get to and from the toilet or bedside commode.
- ¨ ¨ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
- ¨ ¨ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- ¨ ¨ 3 - Unable to get to and from the toilet or bedside com-mode but is able to use a bedpan/urinal independently.
- ¨ ¨ 4 - Is totally dependent in toileting.
- ¨ UK - Unknown
- **DEFINITION:**Identifies the patient's ability to safely get to and from the toilet or bedside commode. Excludes personal hygiene and management of clothing when toileting. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:** Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

MO680 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:** If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders, then Response 1 applies."UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. If the patient can get to and from the toilet during the day, but uses the commode at night for "convenience," Response 0 applies.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely use the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

MO690

- **(M0690) Transferring:** Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.
- Prior Current
- ¨ ¨ 0 - Able to independently transfer.
- ¨ ¨ 1 - Transfers with minimal human assistance or with use of an assistive device.
- ¨ ¨ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
- ¨ ¨ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ¨ ¨ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ¨ ¨ 5 - Bedfast, unable to transfer and is unable to turn and position self.
- ¨ **DEFINITION:** Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:**Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability UK - Unknown

MO690 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**If the patient is able to transfer self, but requires standby assistance to transfer safely, or requires verbal cueing/reminders, then Response 1 applies.Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other, then Response 3 must be selected.If the patient is bedfast, the ability to turn and position self in bed is assessed. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do not mean that the patient is not independent. Observe the patient during transfers and determine the amount of assistance required for safe transfer. If ability varies between the transfer activities listed, record the level of ability applicable to the majority of those activities. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.

MO690 cont.

- CMS is in the process of defining assistive devices, and will provide guidance when the issue is clarified.
- Note that verbal cueing is considered caregiver assistance.
- ***Safety is integral to ability.*** If the patient is not safe when transferring with just minimal human assistance or with an assistive device, they cannot be considered functioning at the level of response "1".
- ***The patient's medical restrictions must be considered in responding, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.***

MO700

- **(M0700) Ambulation/Locomotion:** Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
- Prior Current
- ¨ ¨ 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- ¨ ¨ 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ¨ ¨ 2 - Able to walk only with the supervision or assistance of another person at all times.
- ¨ ¨ 3 - Chairfast, unable to ambulate but is able to wheel self independently.
- ¨ ¨ 4 - Chairfast, unable to ambulate and is unable to wheel self.
- ¨ ¨ 5 - Bedfast, unable to ambulate or be up in a chair.
- ¨ UK - Unknown
- **DEFINITION:**Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

MO700 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**If the patient requires standby assistance to safely ambulate or requires verbal cueing/reminders, then Response 1 or Response 2 applies, depending on the quantity of assistance needed.Responses 3 and 4 refer to a patient who is unable to ambulate, even with the use of assistive devices and assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 3 or 4, based on ability to wheel self."UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item. Medical restrictions should be taken into consideration (as with all other ADL items), as the restrictions address what the patient is able to do safely.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

MO700 cont.

- Endurance is not included in this item.
- "Even and uneven surfaces"
  - Refers to the typical variety of surfaces a patient would routinely encounter in their environment.
  - May include carpeting, rugs, bare floors, transitions from one type of flooring to another, stairs, sidewalks, graveled areas, grass, uneven ground.
  - **Consider activities permitted, the patients current environment and it's impact on the patient's normal routine activities.**
  - Transfers not included in this item.

MO710

- **(M0710)Feeding or Eating:** Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**
- Prior Current
- .. .. 0 - Able to independently feed self.
- .. .. 1 - Able to feed self independently but requires:
- (a) meal set-up; OR
- (b) intermittent assistance or supervision from another person; OR
- (c) a liquid, pureed or ground meat diet.
- .. .. 2 - Unable to feed self and must be assisted or supervised through-out the meal/snack.
- .. .. 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- .. .. 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- .. .. 5 - Unable to take in nutrients orally or by tube feeding.
- .. UK - Unknown
- **DEFINITION:**Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item excludes evaluation of the preparation of food items. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:** Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO710 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**Meal "set-up" (in Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. -- all of which are special adaptations of the meal for the patient.Responses 3, 4, and 5 include non-oral intake."UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Determine the amount and type of assistance that is needed by the patient to feed himself/herself once the food is placed in front of him/her. During the nutritional assessment, determine whether special preparations (i.e., pureeing, grinding, etc.) must occur for food to be swallowed or whether tube feedings are necessary.

MO720

- **(M0720) Planning and Preparing Light Meals** (e.g., cereal, sandwich) or reheat delivered meals:
- Prior Current
- ¨ ¨ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
- (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routine-ly performed light meal preparation in the past (i.e., prior to this home care admission).
- ¨ ¨ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- ¨ ¨ 2 - Unable to prepare any light meals or reheat any delivered meals.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:**Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO720 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**Response 1 indicates patient can intermittently (i.e., sometimes) prepare light meals, while Response 2 indicates patient cannot prepare light meals."UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals (whether or not he/she currently does this)? Utilize observations made during the assessment of cognitive status, ambulation, grooming, dressing, and other activities of daily living (ADLs) to assist in determining the best response to this item. The patient's own dietary requirements should be considered when evaluating the ability to plan and prepare light meals.

MO 720 cont.

- While the nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements and related planning/preparation) should be considered when scoring M0720.
- Therefore a patient who is able to complete the mobility and cognitive tasks that would be required to heat a frozen dinner in the microwave or make a sandwich, but who is currently physically or cognitively *unable* plan and prepare a simple meal that complies with a medically prescribed diet should be scored as a "1- unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations," until adequate teaching/learning has occurred for the special diet, or until related physical or cognitive barriers are addressed.
- If the patient with any prescribed diet requirements is unable to plan and prepare a meal that complies with their prescribed diet AND also is unable to plan and prepare "generic" light meals (e.g. heating a frozen dinner in the microwave or making a sandwich), Response 2 – Unable to prepare any light meals or reheat any delivered meals" should be selected.
- This is a critical assessment strategy when considering the important relationship between this IADL and nutritional status.
- A poorly nourished patient with limited ability to prepare meals is at greater risk for further physical decline. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #8]

Mo 720 cont

- If diet consists entirely of enteral nutrition…
  - The clinician must assess the patients ability to plan and prepare their prescribed diet, not a light meal they wouldn't otherwise consume.
  - Do they know which product they are prescribed and how much they should receive in a day?
  - Can they prepare the feeding?
  - **Note: management and cleaning of equipment is not measured in this item.**

MO730

- **(M0730) Transportation:** Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).
- Prior Current
- ¨ ¨ 0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
- ¨ ¨ 1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
- ¨ ¨ 2 Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the patient's physical and mental ability to safely use a car, taxi or public transportation. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:** Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO730 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to safely use transportation and the type of assistance required. Utilize observations made during the assessment of ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item.

MO730 cont.

- .
- **Q160. M0760. If I select response 0 or response 1, will the patient's homebound status be questioned?**
- A160. For all the ADL/IADL OASIS items, the patient's ability to perform the tasks is the focus of the assessment. The frequency of leaving the home to shop or the amount of effort needed, two criteria often associated with homebound status, are not the assessment focus here. Refer to the Medicare Benefits Policy Manual available at http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf or contact your Regional Home Health Intermediary (RHHI) for issues related to homebound status and other Medicare payment related issues. [Q&A EDITED 08/07]

MO740

- **(M0740)** **Laundry:** Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.
- Prior Current
- ¨ ¨ 0 - (a) Able to independently take care of all laundry tasks; OR
- (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).
- ¨ ¨ 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
- ¨ ¨ 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the patient's physical, cognitive, and mental ability to do laundry, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED:** Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO740 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:** The ability to do laundry is impacted by the patient's environment (i.e., is the washing machine on the same floor, in the same building, etc.). The patient's ability to do laundry in his/her own environment should be considered in responding to this item. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:** A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ability to do laundry, even if this task is not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living to assist in determining the best response to this item. Awareness of the location of laundry facilities (from the environmental assessment) is also needed.

MO750

- **(M0750) Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.
- Prior Current
- ¨ ¨ 0 - (a) Able to independently perform all housekeeping tasks; OR
- (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in house-keeping tasks in the past (i.e., prior to this home care admission).
- ¨ ¨ 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
- ¨ ¨ 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
- ¨ ¨ 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
- ¨ ¨ 4 - Unable to effectively participate in any housekeeping tasks.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the physical, cognitive and mental ability of the patient to perform both heavier and lighter housekeeping tasks, even if the patient does not routinely carry out these activities. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

MO750 cont.

- **TIME POINTS ITEM(S) COMPLETED:**Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability
- **RESPONSE—SPECIFIC INSTRUCTIONS:**"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to complete housekeeping, even if these tasks are not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

MO760

- **(M0760)** **Shopping:** Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.
- Prior Current
- ¨ ¨ 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR
- (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).
- ¨ ¨ 1 - Able to go shopping, but needs some assistance:
- (a) By self is able to do only light shopping and carry small packages, but needs some-one to do occasional major shopping; OR
- (b) Unable to go shopping alone, but can go with someone to assist.
- ¨ ¨ 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
- ¨ ¨ 3 - Needs someone to do all shopping and errands.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

MO760 cont.

- **DEFINITION: Identifies** the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO 760 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS:**"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan for, select, and purchase items from the store, even if these tasks are not routinely performed. How are medications, groceries, or needed medical supplies obtained? Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

MO770

- **(M0770) Ability to Use Telephone:** Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.
- Prior Current
- ¨ ¨ 0 - Able to dial numbers and answer calls appropriately and as desired.
- ¨ ¨ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- ¨ ¨ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- ¨ ¨ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- ¨ ¨ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- ¨ ¨ 5 - Totally unable to use the telephone.
- ¨ ¨ NA - Patient does not have a telephone.
- ¨ UK - Unknown
- **DEFINITION:** Identifies the patient's ability to prepare and take all prescribed inhalant/mist medication reliably and safely and the type of assistance required to administer the current dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

MO770 cont.

- **DEFINITION: Identifies** the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO 770

- **RESPONSE—SPECIFIC INSTRUCTIONS:**"UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Does the patient have access to a telephone? Information obtained during assessment of cognitive, behavioral, and other ADL assessments may be helpful in determining the most accurate response for this item. The safety assessment also provides data regarding emergency plans - how is the ability to use a telephone related to these plans?

MO780

- **MEDICATIONS**
- **(M0780) Management of Oral Medications:** Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**
- Prior Current
- ¨ ¨ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- ¨ ¨ 1 - Able to take medication(s) at the correct times if:
- (a) individual dosages are prepared in advance by another person; OR
- (b) given daily reminders; OR
- (c) someone develops a drug diary or chart.
- ¨ ¨ 2 - Unable to take medication unless administered by someone else.
- ¨ ¨ NA - No oral medications prescribed.
- ¨ UK - Unknown

MO780 cont.

- **DEFINITION:** Identifies the patient's ability to prepare and take all injectable mediations reliably and safely and the type of assistance required to administer the correct dosage at the appropriate time/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today

TIME POINTS ITEM(S) COMPLETED: Start of care – prior and current ability Resumption of care – prior and current ability Follow-up – current ability Discharge from agency – not to an inpatient facility – current ability

RESPONSE—SPECIFIC INSTRUCTIONS: Exclude IV medications. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

MO780 cont.

- **Item intent:** Ability to prepare and take PO meds at right time and dose.
- Assess patient's cognitive and physical status.
- Is there a barrier that impacts their ability to open containers, fill a med box/planner, set up reminders, charts, or lists?
- A patient that utilizes a special method or mechanism in order to take meds correctly is not necessarily dependent. (e.g. bubble packs prepared by pharmacy)

MO780 cont.

- Caregiver/ALF considerations
  - If the family chooses to manage the patients medication regimen, DO NOT AUTOMATICALLY MARK ITEM 2.
  - If the patient lives in an assisted living facility and med management is required as part of their rent, DO NOT AUTOMATICALLY MARK ITEM 2
  - The intent is to do an assessment of the patients ability to safely manage most of their medications if these resources were not there.
  - Ordering and picking up medications, not scored here. Would be scored under shopping.

MO790

- **(M0790) Management of Inhalant/Mist Medications:** Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, in-clud-ing administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**
- Prior Current
- ¨ ¨ 0 - Able to independently take the correct medication and proper dosage at the correct times.
- ¨ ¨ 1 - Able to take medication at the correct times if:
- (a) individual dosages are prepared in advance by another person, OR
- (b) given daily reminders.
- ¨ ¨ 2 - Unable to take medication unless administered by someone else.
- ¨ ¨ NA - No inhalant/mist medications prescribed.
- ¨ UK - Unknown

MO790 cont

- **DEFINITION: Identifies** the patient's ability to prepare and take all prescribed inhalant/mist medication reliably and safely and the type of assistance required to administer the current dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

MO 790 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS: Exclude** oral, injectable, and IV medications. If oxygen is included in the patient's medication regimen, consider it an inhalant medication for this item.“UK - Unknown” is an option only in the “prior” column. This response should be used only if there is no way to determine the patient’s prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening inhalant mist/medications and preparing any other equipment required for administration. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

MO800

- **(M0800) Management of Injectable Medications:** Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
- Prior Current
- ¨ ¨ 0 - Able to independently take the correct medication and proper dosage at the correct times.
- ¨ ¨ 1 - Able to take injectable medication at correct times if:
- (a) individual syringes are prepared in advance by another person, OR
- (b) given daily reminders.
- ¨ ¨ 2 - Unable to take injectable medications unless administered by someone else.
- ¨ ¨ NA - No injectable medications prescribed.
- ¨ UK - Unknown

MO800 cont.

- **DEFINITION: Identifies** the patient's ability to prepare and take all injectable mediations reliably and safely and the type of assistance required to administer the correct dosage at the appropriate time/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care – prior and current ability Resumption of care – prior and current ability Follow-up – current ability Discharge from agency – not to an inpatient facility – current ability

MO 800 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS: Exclude** IV medications."UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- **ASSESSMENT STRATEGIES:**A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

MO 800 cont.

- Reports the patients ability to prepare and take (inject) all prescribed injectable medications that patient is receiving in home while under HH POC.
- Requires assessment of the patients:
  - cognitive and physical ability to draw up correct dose accurately using aseptic technique
  - Inject in an appropriate site using correct technique
  - Dispose of syringe properly

MO 800 cont.

- Includes all injectable medications the patient has received or will receive during the home health POC for the “current” status, and 14 days prior to SOC/ROC for “prior” status
- Note that if an injectable medication is given by a nurse, the clinician will determine if the administration by the nurse was for convince, or if the physician ordered it because of a medical restriction inferring that the patient is unsafe/unable to self inject.
- **Note this is a change from earlier guidance provided in the OASIS Web-Based Training**.

MO 810

- **OASIS ITEM:(M0810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies):** Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)** ¨ 0 - Patient manages all tasks related to equipment completely independently.
- ¨ 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.
- ¨ 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- ¨ 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- ¨ 4 - Patient is completely dependent on someone else to manage all equipment.
- ¨ NA - No equipment of this type used in care **[If NA, go to *M0826*] **** At discharge, change M0826 to M0830.

MO 810
cont.

- **DEFINITION: Identifies** the patient's ability to set up, monitor and change equipment reliably and safely, and the amount of assistance required from another person. The focus is on what the patient is able to do, not on compliance or willingness.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care Resumption of care Discharge from agency - not to inpatient facility

MO 810 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS: Include** only management of oxygen, IV infusion therapy, enteral/parenteral nutrition, and ventilator therapy equipment and supplies. If more than one type of equipment is used, consider the equipment for which the most assistance is needed. If "NA" is selected at discharge, clinician should be instructed to skip to M0830
- .
- **ASSESSMENT STRATEGIES: Is** any of the listed equipment used in care? (Note responses to M0250 and M0500 that address the specified equipment.) If so, a combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient setting up and changing equipment. Ask the patient to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional assessments contribute to determining the response for this item.

MO 820

- **Caregiver Management of Equipment (includes <u>ONLY</u> oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies):** <u>Caregiver's ability</u> to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**
- ¨ 0 - Caregiver manages all tasks related to equipment completely independently.
- ¨ 1 - If someone else sets up equipment, caregiver is able to manage all other aspects.
- ¨ 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task.
- ¨ 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).
- ¨ 4 - Caregiver is completely dependent on someone else to manage all equipment.
- ¨ NA - No caregiver
- ¨ UK - Unknown *
- * At discharge, omit "UK - Unknown

MO 820
cont

- **DEFINITION: Identifies** the caregiver's ability to set up, monitor and change equipment reliably and safely. The focus is on what the caregiver is able to do, not on compliance or willingness. "Caregiver" is defined in M0360.

- **TIME POINTS ITEM(S) COMPLETED: Start** of care Resumption of care Discharge from agency - not to inpatient facility

MO 820
cont

- **RESPONSE—SPECIFIC INSTRUCTIONS: The** definition of equipment includes only oxygen, IV/infusion equipment, enteral/parenteral nutrition and ventilator therapy equipment or supplies. If the patient has no caregiver, mark "NA."If more than one type of equipment is used, consider the equipment for which the most assistance is needed.

- **ASSESSMENT STRATEGIES: Is** any of the listed equipment used in care? (Note responses to M0250 and M0500 that address the specified equipment.) If so, a combined observation/interview approach with the caregiver is required to determine the most accurate response for this item. Observe the caregiver setting up and changing the equipment. Ask the caregiver to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional ability of the caregiver (as evaluated during the visit) contribute to determining the response for this item.

MO 826

- **Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**
- **(**__ __ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
- ¨ NA - Not Applicable: No case mix group defined by this assessment

MO826 cont

- **DEFINITION: Identifies** the total number of therapy visits (physical, occupational or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group. Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the treatment of the patient's illness or injury.
- **TIME POINTS ITEM(S) COMPLETED: Start** of care Resumption of care Follow-up

MO 826 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS: Answer** "000" if no therapy services are needed. Answer "Not Applicable" when this assessment will not be used to determine a Medicare case mix group. Usually, the "Not Applicable" response will be checked for patients whose payment source is not Medicare fee-for-service (i.e., M0150, Response 1 is not checked), or for an assessment that will not be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response to this item is required to generate the case mix code.
- **ASSESSMENT STRATEGIES: When** the patient assessment and the care plan are complete, review the plan to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services are ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.

MO 826 cont.

- 1.60 OASIS Data Specs require that MO826 must report a number that is **"zero filled and right justified"**
- The number of therapy visits entered into MO826 must range from 000 to 999.
- If there are less than 3 digits in the number of therapy visits to report, the number must be preceded by zeros.
- If number is not entered correctly at SOC/Recert, then Medicare will auto adjust for final payment.